066894 SEP 28 87 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 026283
REG. NO

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Glendora Ethel Cell			2a. DATE OF DEATH MONTH DAY YEAR: September 13, 1987	2b. HOUR: P. M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Feb. 26, 1922	6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Federalsburg,	7b. CITIZEN OF WHAT COUNTRY?: Md. U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline MD.	
10. CITY OR TOWN OF DEATH: Federalsburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 105 Charlotte Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Caroline	Federalsburg	YES [X] NO [ ]	105 Charlotte Avenue 21632

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Horace Sullivan	Celia Tull

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	216-12-1821	Paul S. Cell, 105 Charlotte Ave. Federalsburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CRANIAL METASTASES	4 7 86
DUE TO, OR AS A CONSEQUENCE OF (b)	CARCINOMA BREAST	5 13 86
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/9/86, 19____, to 9/13/87, 19____, that (I) (we) last saw the deceased alive on 9/12/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
C. R.W. Bain	MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	9/18/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Callum R.W. Bain, M.D.	415 E. Dover St., Easton, Md. 21601

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Sept. 16, 1987	Maryland Vet. Cem.	Beulah, Dor., Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS		
Framptom-Hawkins F.H.,	216 N. Main St. Federalsburg	SEP 23 1987

DHMH-16 60M 1/73
(VR A 15 (4))

067794 OCT -7 87 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 26284

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the certificate within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 4/83 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Helen	MIDDLE: P.	LAST: Cole	2a. DATE OF DEATH MONTH DAY YEAR: Sept. 27 1987	2b. HOUR: 11:50 AM	
3. SEX: Female	4. RACE: Cauc.	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 31 1895	6. AGE (IN YEARS LAST BIRTHDAY): 91 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Marcus Hook PA	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline MD		
10. CITY OR TOWN OF DEATH: Greensboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Academy Lane	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Caroline	Greensboro	YES ☒ NO ☐	Academy La. 21639

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
unknown	unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		180-03-2338	Howard Cole son Crumpton , MD 21628

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Sepsis

DUE TO, OR AS A CONSEQUENCE OF (b) Intestinal Obstruction

DUE TO, OR AS A CONSEQUENCE OF (c) CHF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robinson Lappin MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	9/29/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dr. Robinson Lappin	Caroline Health Ctr. Goldsboro MD 21636

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9/30/87	Chesterfield Cem.	Centreville, Q.A. MD

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Fellows F.H. Box 270 Millington, MD 21651	OCT 05 1987	Julie Davidson-Rondeau

0677?A OCT -7 67

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 26285

0666775 SEP 24 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MA 5. RETAIN PAGE 5 FOR YOUR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: Raymond F. Corkran, Jr.				2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 9 12 1987	2b. HOUR: 4:00 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 27, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 9 12 1987	2d. HOUR: 6:40 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Williamsburg, Md. U.S.A.	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline MD		
10. CITY OR TOWN OF DEATH: Federalsburg	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 213 Maple Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY: Trucking	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Federalsburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 213 Maple Avenue 21632		
14. FATHER'S NAME FIRST / MIDDLE / LAST: Raymond F. Corkran, Sr.				15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: Gertrude V. Foster		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 215-14-3001		17. INFORMANT: Anne B. Corkran	ADDRESS: Federalsburg, Md. 213 Maple Ave.,	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BROKEN NECK — Acute
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) HANGING — Acute
DUE TO, OR AS A CONSEQUENCE OF (c) SUICIDE

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): CARCINOMA, DEPRESSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Christian Jensen M.D. (TYPE/SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED: 9/16/87

EXAMINER'S NAME (TYPE OR PRINT): Christian Jensen, M.D. ADDRESS: P.O. Box 690, Denton MD 21629

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Sept. 15, 1987	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Federalsburg, Caroline, Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Framptom-Hawkins Funeral Home, 216 N. Federalsburg, Md. — 25a. DATE REC'D. BY REGISTRAR: SEP 23 1987

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

0 0 6 8 7 5 SEP 24 87

67018 SEP 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG. NO. 87 26280

1. DECEASED NAME (TYPE OR PRINT): FIRST William MIDDLE Harvey LAST Fleming
2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 9 DAY 17 YEAR 1987
2b. HOUR M
3. SEX: Male
4. RACE: Cau.
5. DATE OF BIRTH: MONTH 3 DAY 30 YEAR 22
6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. IF UNDER 1 YR. MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD: MONTH 9 DAY 17 YEAR 1987
2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline MD
10. CITY OR TOWN OF DEATH: Greensboro
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Boyce Mill Rd. 21639
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Power Service Oper
12b. KIND OF BUSINESS OR INDUSTRY: Nylon Co.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Caroline
13c. CITY OR TOWN: Greensboro
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Boyce Mill Rd. 21639

14. FATHER'S NAME: FIRST Dillon MIDDLE LAST Fleming
15. MOTHER'S MAIDEN NAME: FIRST Rose MIDDLE LAST Young
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): yes (IF YES, GIVE WAR OR DATES): WW 11
16b. SOCIAL SECURITY NO.: 216-16-7111
17. INFORMANT: Sylvia Fleming ADDRESS: Greensboro, Md. 21639

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION, ACUTE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ACUTE
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): HYPERTENSIVE CARDIOVASCULAR DISEASE — chronic
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CORONARY ARTERY DISEASE WITH ANGINA

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Christian P. Jensen M.D. TITLE (SPECIFY): DEPUTY MEDICAL EXAMINER DATE SIGNED: 9/18/87

EXAMINER'S NAME (TYPE OR PRINT): CHRISTIAN E. JENSEN MD ADDRESS: P.O. Box 690, Denton MD 21629

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 9-21-87
23c. NAME OF CEMETERY OR CREMATORY: Greensboro Cemetery
23d. LOCATION CITY OR TOWN: Greensboro COUNTY: Caroline STATE: Md.
24. FUNERAL DIRECTOR NAME: John E. Boulais ADDRESS: Greensboro, Md.
25a. DATE REC'D BY REGISTRAR: SEP 28 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Gardner

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

066811 1 SEP 25 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

26287

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Thomas	Middle: Nelson	Last: Jester	2a. DATE OF DEATH Month: September Day: 13 Year: 1987	2b. HOUR: 12:35 P M	
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: July 1, 1923	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Delaware	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Caroline Md.		
10. CITY OR TOWN OF DEATH: Denton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Towers Road	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: Auto		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Denton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Towers Rd. 21629	
14. FATHER'S NAME First: Thomas	Middle: Luther	Lost: Jester	15. MOTHER'S MAIDEN NAME First: Mary	Middle: Ellen	Last: Breeding
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213227002	17. INFORMANT: Carolyn Jester, Denton, MD 21629			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic renal insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c): hepato renal syndrome

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Polycythemia rubra vera – cirrhosis – COPD – Gout

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 9/13, 19 87, to 9/13, 19 87, that (I) (we) last saw the deceased alive on 9/13, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Albert T. Dawson Jr MD — DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 9/18/87

22d. PHYSICIAN'S NAME (Type): ALBERT T. DAWSON JR — 22e. ADDRESS: Route 3 Box 127 Easton Maryland 21601

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/16/87	Denton Cemetery	Denton Caroline MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Moore Funeral Home	Rt. 12 2nd St. Denton	SEP 24 1987	Julia Davidson Rudasill

DHMH - 163/72 25M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

066725 SEP 24 87

26288

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

1. DECEASED-NAME (Type or print) First: Joseph	Middle: Carlton	Last: Mandrell	2a. DATE OF DEATH Month: September Day: 4 Year: 1987	2b. HOUR: 1:00 PM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH: Sept. 20, 1905	6. AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Caroline County Md.	
10. CITY OR TOWN OF DEATH: Denton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 312 Fifth Avenue	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Owner/Operator	12b. KIND OF BUSINESS OR INDUSTRY: MotorCoach	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Caroline	13c. CITY OR TOWN: Denton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 312 Fifth Ave. 21629
14. FATHER'S NAME First: John	Middle	Last: Mandrell	15. MOTHER'S MAIDEN NAME First: Ida	Middle: Mae Last: Fleetwood
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214326859	17. INFORMANT Address: Virginia Mandrell, Denton, MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Metastatic lung cancer

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING [ ]	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9/3 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J Allen MD DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 9/8/87	
22d. PHYSICIAN'S NAME (Type): J CORWIN MD	22e. ADDRESS: P.O. BOX 660 DENTON MD 21629		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9/8/87	23c. NAME OF CEMETERY OR CREMATORY: Denton Cemetery	23d. LOCATION (City or Town) (County) (State): Denton Caroline MD	
24. FUNERAL DIRECTOR: Moore Funeral Home P.A.	ADDRESS: 12 2nd St Denton	25a. REC'D BY REGISTRAR DATE: SEP 15 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH - 16 3/72 25M
(VR A15 (4))

5

066697 SEP 24 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 26287

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or coroner, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Ethel		MCALLISTER	Sept 10, 1987	5:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	Oct. 29, 1901	85 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH		
Delaware	U.S.A.		Caroline MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Denton	Caroline Nursing Home	Secretary	Insurance		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Caroline	Preston	YES ☐ NO ☑	RD#2 Box 276 Preston, Md. 21655

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Edward	W.	Wootten	Martha	E.	Truitt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		214.32-2357	Mrs. Jean Wright	RD#276 Preston, Md. 21655

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	Acute
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Artery Occlusion	Acute
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	Chronic

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c): Metastatic Carcinoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/7 87 2 19 80, to 9/10 19 87, that (I) (we) last saw the deceased alive on 9/7 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE, DEGREE	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED
Christian Jensen MD		9/10/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
CHRISTIAN E. JENSEN MD	P.O. Box 690, Denton MD 21629

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9/12/87	Jr. Older Cemetery	Preston Caroline Md.

24. FUNERAL DIRECTOR (NAME)	ADDRESS	25a. DATE RECD. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harvey Williams	Frederickburg, MD	SEP 16 1987	Julia Dickson-Bradley

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

067375 OCT -1 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

87 26290 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Sherwood	Middle: S.	Last: Wallace	2a. DATE OF DEATH Month: 9 Day: 20 Year: 87	2b. HOUR 8:14 AM	
3. SEX: M	4. RACE: B	5. DATE OF BIRTH Month: 11 Day: 22 Year: 02	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline County MD.		
10. CITY OR TOWN OF DEATH: Denton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Westerport Healthcare Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Writer	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Talbot	13c. CITY OR TOWN: Easton	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET ADDRESS: R#5 Box 775 21601	
14. FATHER'S NAME First: Scott	Middle:	Last: Wallace	15. MOTHER'S MAIDEN NAME First: Cora	Middle:	Last: Gibson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.	17. INFORMANT: Caroline Jenkins	ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lung Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19: N/A	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): N/A		
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐: N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.): N/A	21f. LOCATION STREET: N/A	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept. 9, 19 87, to Sept. 20, 19 87, that (I) (we) last saw the deceased alive on Sept. 20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Monica Lynn Agree MD	DEGREE: MD	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 9/20/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Monica Lynn Agree MD	22e. ADDRESS: Denton, MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 9/24/87	23c. NAME OF CEMETERY OR CREMATORY: Richardson Cem	23d. LOCATION CITY OR TOWN: Easton	COUNTY: TA	STATE: MD
24. FUNERAL DIRECTOR NAME: Hugo Duckett	ADDRESS: 31 Fourth St. Easton MD	25a. DATE REC'D. BY REGISTRAR: SEP 30 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum		

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

066812 SEP 25 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 26291

1. DECEASED NAME (TYPE OR PRINT) FIRST: Violet	MIDDLE	LAST: Welsh	2a. DATE OF DEATH MONTH DAY YEAR: 9-19-87	2b. HOUR: 8 15 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: April 4 1904	6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Caroline County MD.		
10. CITY OR TOWN OF DEATH: Denton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Wesleyan Health Care Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSE MAKER	12b. KIND OF BUSINESS OR INDUSTRY: N/A		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Delaware	RENT	Dover	YES ☒ NO ☐	81 Morris Drive 99999

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
N/A	N/A

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Unknown-doubtful	221 28 2312	Son James L. Welsh	114 Lotor St. Dover, Del 19901

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Source unknown

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
☐	N/A	N/A

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
N/A	N/A	N/A

22a. I certify that (I) (this hospital) attended the deceased from July 15, 19 87, to Sept-19, 19 87, that (I) (we) last saw the deceased alive on Sept. 12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Monica Agree MD	MD	☐ ☒ ☐	9-19-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Monica Agree MD	Denton, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	9-22-87	Lakeside	Dover Kent Del.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
William Fleischauer & Memorial Del 19953	SEP 24 1987	Julia Davidson-Landau

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 18 60M 7/84 (VRA 15-4)